STATE OF WASHINGTON

OFFICE OF
INSURANCE COMMISSIONER

BEFORE THE INSURANCE COMMISSIONER OF THE STATE OF WASHINGTON

In the Matter of	)	No. D 99 - 93
QUAL MED WASHINGTON HEALTH PLAN, INC.,	)	Consent Order
A Registered Health Maintenance Organization.	)	Levying a Fine
	)	

FINDINGS OF FACT:

The Office of the Insurance Commissioner ("OIC") has made the following findings:

1. QualMed Washington Health Plan, Inc. ("QualMed" or the "Company") is a health maintenance organization registered to do business in the State of Washington.
2. In April 1998, the Office of the Insurance Commissioner met with the region's leading emergency room directors. The emergency room directors were concerned that insurance carriers were denying valid emergency room claims, thereby discouraging the public from seeking emergency care and posing a serious potential health risk to the public.
3. The following month the OIC launched an investigation of whether carriers, including QualMed, were complying with the new emergency room law, RCW 48.43.093. The law went into effect January 1, 1998.
4. The investigation focused on emergency room claims during the first four months of 1998. The OIC found that QualMed processed 11,246 emergency room claims during that period, of which 1,921 were initially denied. The OIC examined a sample of those denials, using techniques approved by the National Association of Insurance Commissioners (NAIC).

5. The sample size of 217 claims had a confidence level of 97.65% and a margin of error of only 2.35%, surpassing NAIC-approved standards. The OIC found that 113, or 52%, of the sampled denials were unlawful.
6. The investigation revealed that it was the Company's practice to deny any emergency room claim that did not include an emergency room report. These denials were made even in cases, such as broken bones or major wounds, where it was clear that an emergency existed. In some cases, it was difficult to determine whether an emergency existed from the initial claim filing. The Company did not conduct an investigation prior to denying the claim. The denials advised the provider and member of what additional information (such as emergency room reports) would be required for the claims to be reconsidered. 74 of the 113 challenged claims in the sample were paid once additional information was submitted and further review done.
7. The OIC found that it took QualMed over six weeks, on average, to deny an emergency room claim, and over twelve weeks, on average, to reverse its decision and pay the claim. Some of the delay in processing some of the claims was caused by providers who did not promptly furnish QualMed with requested information.
8. Although it was not the Company's standard practice to do so, QualMed denied nine claims in the sample because the patients did not have a referral from a primary care physician, even when patients were suffering from an emergency medical condition. Most of these claims were for procedures such as CT scans that were billed separately from the emergency room fees and were not matched to the emergency room claims through a cross-checking process as appropriate to pay.
9. QualMed uses Independent Practice Associations (IPAs) to administer some of its claims. The Company failed to exercise adequate oversight of the IPAs to ensure compliance with Washington law. As a result, some of the claims in the sample were denied by an IPA because the patient did not have a referral.
10. QualMed relied on a highly automated claims handling process. The system had technical flaws and did not allow for sufficient human intervention to evaluate claims. That system made it difficult to cross-check claims before processing to ensure that all claims related to a valid emergency room visit were also paid.
11. QualMed failed to revise its member and provider contracts to reflect the new emergency room law. The law compels insurance carriers to cover the cost of screening and stabilizing patients when a prudent layperson would have sought emergency care under the same circumstances. QualMed's member and provider contracts defined a "Medical Emergency" as "circumstances which a reasonably prudent person would regard as the onset of a sudden or acute illness or injury requiring immediate medical care such that the Member's life or health would have been jeopardized had the care been delayed." The agreements also provided that the "existence and duration of a Medical Emergency shall be determined solely by QualMed in the exercise of its reasonable judgment." The OIC believes the latter language misleads consumers and providers into believing that the Company was the sole arbiter of whether an emergency room claim would be covered.
12. QualMed did not submit network adequacy reports to the OIC on a timely basis in 1998 and 1999. The Company also failed to provide the OIC network adequacy information during a recent investigation of health care access in southwest Washington.
13. There is no indication that QualMed intentionally violated the emergency room law. The violations at issue here occurred during the first four months that the law went into effect.
14. QualMed has recently cooperated and taken steps to remedy the problems identified by the OIC's investigation.

CONCLUSIONS OF LAW:

The OIC, as a result of its investigation, has reached the following conclusions:

1. QualMed's improper denial of emergency room claims is a violation of RCW 48.43.093.
2. QualMed's improper handling of emergency room claims is a violation of RCW 48.43.093.

3. QualMed's distribution of inaccurate, misleading contracts and handbooks to providers and consumers is a violation of RCW 48.43.093.
4. QualMed's failure to meet network reporting requirements on a timely basis is a violation of WAC 284-43-220.
5. RCW 48.05.185 and RCW 48.46.135 authorize the Commissioner to impose a fine in lieu of the suspension or revocation of a company's certificate of registration.

CONSENT TO ORDER

QualMed wishes to resolve this matter without further administrative or judicial proceedings. QualMed agrees with the OIC that certain modifications to the practices identified above are consistent with the best interests of the health plan and its members, and QualMed will therefore implement the agreed upon modifications.

The Commissioner has offered a settlement in lieu of suspending or revoking QualMed's certificate of registration or imposing any other applicable penalty following final resolution of the matter through a full adjudicative process.

QualMed hereby consents to entry of this order. By agreement of the parties, the OIC will impose a fine of $500,000, with $250,000 suspended, on condition that:

1. QualMed pay $250,000 of the fine for its violations of Washington insurance law within thirty days of the entry of this order.
2. QualMed pay the following valid emergency room claims which were submitted for services rendered in the first four months of 1998:

- 980401192
- 980860262
- 980890500
- 980164001397
- 980634001154
- 980704001711
- 980864000005
- 980894000227
- 980914000056
- 980974000668
- 981054001595
- 981144991173
- 981174001734
- 981274000281
- 981314001468
- 981314001585

1. QualMed implement the Emergency Care Claims Quality Improvement Process set forth in Exhibit A. The OIC recognizes that the Company processes thousands of claims; the OIC therefore will not seek additional payment from QualMed or proceed against QualMed=s certificate should the Company wrongfully deny isolated emergency room claims, as determined by the OIC. The Company commits to paying such claims promptly once the inappropriate denials are brought to its attention. QualMed shall abide by the Emergency Care Claims Quality Improvement Process until such time as the Agreement on Emergency Room Claims, referenced below, in condition 4, becomes effective.
2. QualMed shall abide by the Agreement on Emergency Room Claims set forth in Exhibit B,

as may be modified by the Commissioner, at such time as such Agreement becomes legally binding and enforceable upon the five largest carriers in the health insurance or prepaid health plan market in the State of Washington (other than QualMed), as measured by percentage market share of premium revenue.

3. QualMed shall abide by the Contract Revision Plan set forth in Exhibit C.

QualMed shall also file all outstanding network adequacy reports due in 1999.

This fine must be paid in full within thirty days of the entry of this order. Pursuant to RCW 48.05.185, failure to pay the fine within the allotted time shall constitute grounds for revocation of the insurer's certificate of registration, and for the recovery of the fine in a civil action brought on behalf of the Insurance Commissioner by the Attorney General of the State of Washington.

QualMed acknowledges its duty to comply fully with the applicable laws of the State of Washington.

EXECUTED this _____ day of August, 1999.

_____

Mark C. Rattray, M.D.

President

QualMed Washington Health Plan, Inc.

ORDER

Pursuant to RCW 48.05.185, the Insurance Commissioner hereby imposes a fine of five hundred thousand dollars, with two hundred fifty thousand dollars suspended, upon QualMed Washington Health Plan, Inc. The $250,000 fine must be paid in full within thirty days of the date of entry of this order. Failure to pay the fine within the allotted time shall constitute grounds for the revocation of the insurer's certificate of registration, and for the recovery of the fine in a civil action brought on behalf of the Insurance Commissioner by the Attorney General of the State of Washington.

QualMed will perform conditions one through five as set forth in the Consent to Order section, incorporated herein by reference. The Commissioner may impose the balance of the suspended payment and suspend or revoke QualMed's certificate of registration should the company fail to meet the conditions set forth in the AConsent to Order."

ENTERED AT OLYMPIA, WASHINGTON, this _____ day of _____1999.

DEBORAH SENN

Insurance Commissioner

By

Jeffrey Coopersmith

Deputy Commissioner Legal Affairs

Exhibit A

Emergency Care Claims

Quality Improvement Process

A quality improvement process related to the adjudication of emergency care claims has been developed. This document establishes a consistent guideline for the automatic payment of emergency care claims on the first level review by claims department personnel and the situations in which the claim is sent to Medical Management for review. The following processes have been implemented or will be implemented no later than September 30, 1999.

1. A through put process to pay emergency care claims by diagnosis code was implemented in September of 1998. One hundred seventy diagnoses and related codes were instituted for automatic payment. Thirty-four additional diagnoses and related codes were added to this list in March of 1999. These ICD-9 codes identified as generally representing emergency care diagnoses will be paid without Medical Management review and without medical records, subject to meeting eligibility and coverage requirements. In addition, we will implement a policy whereby claims up to $250.00 will be approved by the claims department staff without Medical Management review or request for records.
2. All emergency care claims associated with an inpatient admission on the same day will be paid in accordance with the inpatient contract. If an inpatient claim is denied for no prior authorization or lack of medical necessity, Medical Management will review the claim to see if it includes charges for ER services. If it does, the provider will be notified to submit a separate claim for the charges associated with the ER care and that ER claim will be processed in accordance with the ER claims process.
3. Claims which are determined to have a corresponding referral to the emergency department by the Nurse Call Line, the Health Plan or the PCP for the date and time of visit will be processed and paid without Medical Management review.
4. Any emergency care claim that does not fall into a category for automatic approval and does not have notes attached will be reviewed by Medical Management to determine if the claim can be paid on the basis of the claim form alone. This review shall be completed within 5 business days 90% of the time. If the information is insufficient, the claim will be pended for 21 calendar days, a letter will be generated and sent to the emergency department requesting notes, indicating the time line to submit the notes and stating that the claim will be denied if the notes are not provided. If notes are not submitted then the claim may be denied for no ER notes and an explanation of payment issued. The pended claims will be reprocessed within a reasonable time frame after the 21 days have passed. If a claim is subsequently resubmitted with proper documentation, it will be reconsidered in accordance with the process described above.
5. QualMed will educate the IPAs with which it contracts about the Washington emergency room claim law and will ensure their compliance with that law for QualMed claims. This provision shall not be construed to increase QualMed's liability for the actions of IPAs beyond the provisions of existing law.

EXHIBIT B

AGREEMENT ON EMERGENCY ROOM CLAIMS

RCW 48.43.093 requires health insurance carriers to cover the cost of screening and stabilizing emergency room patients when a prudent layperson would have sought emergency treatment under the same circumstances.

The Office of the Insurance Commissioner ("OIC") recognizes a carrier's right to investigate certain emergency room claims. To comply with RCW 48.43.093, carriers must follow, at minimum, these procedures:

1. Pay all emergency room claims where the use of the emergency room cannot reasonably be challenged. Such claims include, but are not limited to, those involving loss of consciousness, severe pain, altered mental status, high fever, broken bones, serious injuries, open wounds, and the sudden onset of symptoms that a prudent layperson might believe requires emergency care, regardless of the final diagnosis, where there is no issue of a policy exclusion. Payment must be made within thirty days of receipt of such claims.

2. Carriers may investigate claims where use of the emergency room might reasonably be disputed. Such claims include those where treatment might be for routine treatment of chronic conditions, certain follow-up care, and minor injuries not requiring emergency medical care, and those involving possible policy exclusions. Carriers must refer such claims to medical management. The review must be completed within fifteen days of receipt of the claim.

3. If the carrier chooses to investigate a claim further, it must pend the claim. Within fifteen days following receipt of the claim, the carrier must send a notice to the member and the provider stating the reason for investigating the claim, the additional information required to make a final determination, and the date the additional information must be received by the carrier. The notice must also state that the claim may be denied unless the requested information is provided within the allotted time.

4. After thirty days have elapsed from the date the notice was sent out, the carrier may deny the claim if the provider or member fails to submit the requested information. The denial must state the basis for denial of the claim and that the claim will be reconsidered should the information be provided. Before denying the claim, the carrier must first review all information it has gathered on the disputed claim and any related claim to see whether there is sufficient information to pay the claim.

5. Once the carrier receives the requested information, regardless of whether the original deadline for submitting the information has passed, it must pay or deny the claim within fifteen days. The carrier must immediately notify the provider and member of its action. If the claim is denied, the carrier must state the basis of the denial, and set out fully and clearly the appeal rights.

6. All notices and other correspondence related to the disputed claim must be in plain, easily understood language. Whenever a carrier disputes an emergency room claim, notice of such dispute must be sent to the provider and member.

7. Claims for emergency services with the same date of service, up to $250, should be paid without further investigation.

8. If a member is admitted to the hospital from the emergency room, and the hospital confinement is denied for any reason, the carrier must pay the emergency room facility charge and any other obvious ER charges listed on the hospital bill within thirty days of receipt of the claim. The carrier may request separate billing from the provider for other ER charges as needed. Emergency room charges mean those services initiated in the emergency room department to screen and stabilize a patient.

9. The OIC recognizes that carriers process a high volume of claims. Carriers must meet the

foregoing standards for at least 90% of their disputed emergency room claims.

10. It is a violation of law to deny emergency room claims for lack of a referral, lack of prior authorization, service outside of a carrier's service area, or service outside of a carrier's network.

11. While it is a violation of law to require a referral for an emergency room claim, those claims that do have referrals from carrier personnel or the patient's primary care physician for the date and time of the visit shall be paid without medical management review.

12. If there are multiple reasons for investigating a claim, the carrier must ask for all additional information at one time. The carrier may not make "serial" requests for information. If the carrier receives the requested information and it is incomplete or raises new issues, the carrier may continue its investigation.

13. Carriers shall file, by December 31 of each year, a report with the Office of the Insurance Commissioner showing the following:

a. The number of emergency room claims submitted

b. The number of emergency room claims paid

c. The number of emergency room claims disputed

d. The number of emergency room claims denied